Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 11/14/01?

   b. The request was received on 02/15/02.

II. EXHIBITS

1. Requestor, Exhibit 1:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA's
   c. EOB
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:

   a. TWCC 60 and/or Response to a Request for Dispute Resolution
   b. HCFA's
   c. Carrier's methodology
   d. Audit summaries/EOB
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (4), the carrier representative did not have a sign copy for this dispute. Based on 133.307 (i) Medical Dispute Resolution is unable to determine if the insurance carrier's response is timely. Therefore, the response will be considered timely.

III. PARTIES' POSITIONS

1. Requestor:

   a. The Requestor asserts that charges were for facility fees not professional fees. The payment received only represents 29% of the total billed amount. Other workers' compensation carriers reimburse at 85-100%. Additional reimbursement is sought
   b. in the amount of $1,228.17 for date of service 11/14/01.

2. Respondent:

   a. The Carrier denies additional reimbursement in the amount of $1,228.17 for the date of service 11/14/01.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 11/14/01.

2. The provider billed a total of $1,736.82 for the date of service 11/14/01.

3. The carrier reimbursed a total of $508.65 for the date of service 11/14/01. The EOBs state, "No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area."

4. The amount in dispute per the TWCC 60 is $1,228.17, the difference between the billed amount and the reimbursement received for date of service 11/14/01.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The provider has submitted reimbursement data to document what they consider fair and reasonable reimbursement. The provider has submitted EOBs from other carriers, these EOBs indicate that the provider has accepted from 85% to 100% of the billed amount as fair and reasonable reimbursement. The provider's documentation does provide some evidence of fair and reasonable reimbursement.

The Carrier has also submitted reimbursement data to document what they consider fair and reasonable reimbursement, and to comply with Commission Rule 133.304 (i)(1-4). The carrier's methodology incorporates information from 6 different states that have adopted a system to determine ASC charges based on intensity levels. The range is from 1 (low) to 8 (high), determined based on where the CPT code falls in the HCFA intensity grouper list. The carrier averaged the payments in each level for the 6 states and designed this as the base fee for each intensity level. The carrier also takes into account local economic factors and applies HCFA's wage index factor to the base fees. If the specific area is not addressed in the wage index, the carrier uses the state average. Any extraordinary supply costs and lab tests are reimbursed as well, above and beyond the base fee and wage index. Therefore, additional reimbursement **is not** recommended.

The above Findings and Decision are hereby issued this 20th day of May 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb